

**Step 1: Basic Client Information**

Please complete the following basic client information and note that all fields with an \* are required fields. Universal Data Elements are required for all project participants. The response "Data Not Collected" means the question was not asked of the client and will report as missing on reports.

Basic Client Information:\*

First Name: \* \_\_\_\_\_ Last Name: \* \_\_\_\_\_

Middle Name: \_\_\_\_\_ Suffix: \_\_\_\_\_

**Step 2: Project Update/Annual Assessment**

Complete the project enrollment information and please note all fields with an \* are required fields. Complete additional forms for each household member enrolled.

Project Start Date: \* \_\_\_\_\_ Case Manager: \* \_\_\_\_\_

Housing Move-In Date: \* \_\_\_\_\_ (enter date client took occupancy of unit)

Assessment Type: \* ☐ Update ☐ Annual Assessment Date: \* \_\_\_\_\_

Covered by Health Insurance:\*

- ☐ Yes ☐ No  
☐ Client Doesn't Know ☐ Client Refused  
☐ Data Not Collected

Type of Insurance:\*

- |  |   |
|--|---|
| <input type="checkbox"/> Medicaid  | <input type="checkbox"/> Private Pay Health Insurance                       |
| <input type="checkbox"/> Medicare  | <input type="checkbox"/> State Health Insurance for Adults (HIP or HIP 2.0) |
| <input type="checkbox"/> State Children's Health Insurance Program (S-CHIP; not Medicaid or HIP) | <input type="checkbox"/> Indian Health Service (Native American)            |
| <input type="checkbox"/> Veteran's Administration (VA) Medical Services                          | <input type="checkbox"/> Other Public                                       |
| <input type="checkbox"/> Health Insurance Obtained through COBRA                                 | <input type="checkbox"/> Other _____  |

Insurance Status:\*

- |  |   |
|--|---|
| <input type="checkbox"/> Active            | <input type="checkbox"/> No                                 |
| <input type="checkbox"/> Start Date: _____ | <input type="checkbox"/> Applied; decision pending          |
| <input type="checkbox"/> End Date: _____   | <input type="checkbox"/> Applied; client not eligible       |
|  | <input type="checkbox"/> Client did not apply               |
|  | <input type="checkbox"/> Insurance type N/A for this client |
|  | <input type="checkbox"/> Client Doesn't Know                |
|  | <input type="checkbox"/> Client Refused                     |
|  | <input type="checkbox"/> Data Not Collected                 |

HMIS Barriers Assessment:\*

**Alcohol Abuse**

Barrier Present?

- |  |   |
|--|---|
| <input type="checkbox"/> Yes                 | <input type="checkbox"/> No             |
| <input type="checkbox"/> Client Doesn't Know | <input type="checkbox"/> Client Refused |
| <input type="checkbox"/> Data Not Collected  |   |

Condition is Indefinite?

- |  |   |
|--|---|
| <input type="checkbox"/> Yes                 | <input type="checkbox"/> No             |
| <input type="checkbox"/> Client Doesn't Know | <input type="checkbox"/> Client Refused |
| <input type="checkbox"/> Data Not Collected  |   |

**Developmental Disability**

Barrier Present?

- |  |   |
|--|---|
| <input type="checkbox"/> Yes                 | <input type="checkbox"/> No             |
| <input type="checkbox"/> Client Doesn't Know | <input type="checkbox"/> Client Refused |
| <input type="checkbox"/> Data Not Collected  |   |

Condition is Indefinite?

- |  |   |
|--|---|
| <input type="checkbox"/> Yes                 | <input type="checkbox"/> No             |
| <input type="checkbox"/> Client Doesn't Know | <input type="checkbox"/> Client Refused |
| <input type="checkbox"/> Data Not Collected  |   |

**Drug Abuse**

Barrier Present?

- |  |   |
|--|---|
| <input type="checkbox"/> Yes                 | <input type="checkbox"/> No             |
| <input type="checkbox"/> Client Doesn't Know | <input type="checkbox"/> Client Refused |
| <input type="checkbox"/> Data Not Collected  |   |

Condition is Indefinite?

- |  |   |
|--|---|
| <input type="checkbox"/> Yes                 | <input type="checkbox"/> No             |
| <input type="checkbox"/> Client Doesn't Know | <input type="checkbox"/> Client Refused |
| <input type="checkbox"/> Data Not Collected  |   |

**HIV/AIDS**

Barrier Present?

- |  |   |
|--|---|
| <input type="checkbox"/> Yes                 | <input type="checkbox"/> No             |
| <input type="checkbox"/> Client Doesn't Know | <input type="checkbox"/> Client Refused |
| <input type="checkbox"/> Data Not Collected  |   |

**HIV/AIDS Continued**

Condition is Indefinite?

- |  |   |
|--|---|
| <input type="checkbox"/> Yes                 | <input type="checkbox"/> No             |
| <input type="checkbox"/> Client Doesn't Know | <input type="checkbox"/> Client Refused |
| <input type="checkbox"/> Data Not Collected  |   |

**Mental Health**

Barrier Present?

- |  |   |
|--|---|
| <input type="checkbox"/> Yes                 | <input type="checkbox"/> No             |
| <input type="checkbox"/> Client Doesn't Know | <input type="checkbox"/> Client Refused |
| <input type="checkbox"/> Data Not Collected  |   |

Condition is Indefinite?

- |  |   |
|--|---|
| <input type="checkbox"/> Yes                 | <input type="checkbox"/> No             |
| <input type="checkbox"/> Client Doesn't Know | <input type="checkbox"/> Client Refused |
| <input type="checkbox"/> Data Not Collected  |   |

**Physical Disability**

Barrier Present?

- |  |   |
|--|---|
| <input type="checkbox"/> Yes                 | <input type="checkbox"/> No             |
| <input type="checkbox"/> Client Doesn't Know | <input type="checkbox"/> Client Refused |
| <input type="checkbox"/> Data Not Collected  |   |

Condition is Indefinite?

- |  |   |
|--|---|
| <input type="checkbox"/> Yes                 | <input type="checkbox"/> No             |
| <input type="checkbox"/> Client Doesn't Know | <input type="checkbox"/> Client Refused |
| <input type="checkbox"/> Data Not Collected  |   |

**Chronic Health Condition**

Barrier Present?

- |  |   |
|--|---|
| <input type="checkbox"/> Yes                 | <input type="checkbox"/> No             |
| <input type="checkbox"/> Client Doesn't Know | <input type="checkbox"/> Client Refused |
| <input type="checkbox"/> Data Not Collected  |   |

Condition is Indefinite?

- |  |   |
|--|---|
| <input type="checkbox"/> Yes                 | <input type="checkbox"/> No             |
| <input type="checkbox"/> Client Doesn't Know | <input type="checkbox"/> Client Refused |
| <input type="checkbox"/> Data Not Collected  |   |

Domestic Violence Assessment of Victim:\*

Is client a victim of domestic violence:\*

- |  |   |
|--|---|
| <input type="checkbox"/> Yes                 | <input type="checkbox"/> No             |
| <input type="checkbox"/> Client Doesn't Know | <input type="checkbox"/> Client Refused |
| <input type="checkbox"/> Data Not Collected  |   |

Currently Fleeing:\*

- |  |   |
|--|---|
| <input type="checkbox"/> Yes                 | <input type="checkbox"/> No             |
| <input type="checkbox"/> Client Doesn't Know | <input type="checkbox"/> Client Refused |
| <input type="checkbox"/> Data Not Collected  |   |

If yes, when experience occurred:\*

- |  |
|--|
| <input type="checkbox"/> Within the past three months                          |
| <input type="checkbox"/> Three to six months ago (excluding 6 months exactly)  |
| <input type="checkbox"/> Six months to one year ago (excluding 1 year exactly) |
| <input type="checkbox"/> One year ago or more                                  |
| <input type="checkbox"/> Client Doesn't Know                                   |
| <input type="checkbox"/> Client Refused  |
| <input type="checkbox"/> Data Not Collected                                    |

Medical Assessment:\*

Medical Assistance Type:\*

- ☐ Receiving public HIV/AIDS medical assistance
- ☐ Yes ☐ No
- ☐ Client Doesn't Know ☐ Client Refused
- ☐ Data Not Collected

If No, Reason No (if applicable):

- ☐ Applied; decision pending
- ☐ Applied; client not eligible
- ☐ Client Did Not Apply
- ☐ Insurance Type N/A for this Client
- ☐ Client Doesn't Know
- ☐ Client Refused
- ☐ Data Not Collected

Receiving AIDS Drug Assistance Program (ADP)

- ☐ Yes ☐ No
- ☐ Client Doesn't Know ☐ Client Refused
- ☐ Data Not Collected

If No, Reason No (if applicable):

- ☐ Applied; decision pending
- ☐ Applied; client not eligible
- ☐ Client Did Not Apply
- ☐ Insurance Type N/A for this Client
- ☐ Client Doesn't Know
- ☐ Client Refused
- ☐ Data Not Collected

T-Cell (CD4) Count Available:\*

- ☐ Yes Date: \* \_\_\_\_\_ T-Cell Count: \* \_\_\_\_\_ ☐ Client Report
- ☐ No ☐ Medical Report
- ☐ Client Doesn't Know ☐ Other
- ☐ Client Refused
- ☐ Data Not Collected

Viral Load Available:\*

- ☐ Available Date: \* \_\_\_\_\_ Viral Load: \* \_\_\_\_\_ ☐ Client Report
- ☐ Not Available ☐ Medical Report
- ☐ Undetectable ☐ Other
- ☐ Client Doesn't Know
- ☐ Client Refused
- ☐ Data Not Collected

Financial Assessment:\* Cash Income: \* ☐ Yes ☐ No

- ☐ Earned Income \$ \_\_\_\_\_
- ☐ Unemployment Insurance \$ \_\_\_\_\_
- ☐ Supplemental Security Income \$ \_\_\_\_\_
- ☐ Social Security Disability Income \$ \_\_\_\_\_
- ☐ VA Service-Connected Disability \$ \_\_\_\_\_
- ☐ VA NonService-Connected Disability \$ \_\_\_\_\_
- ☐ Private Disability Insurance \$ \_\_\_\_\_
- ☐ Worker's Compensation \$ \_\_\_\_\_
- ☐ TANF \$ \_\_\_\_\_
- ☐ General Assistance (GA) \$ \_\_\_\_\_
- ☐ Retirement (Social Security) \$ \_\_\_\_\_
- ☐ Pension/Retirement Former Job \$ \_\_\_\_\_
- ☐ Child Support \$ \_\_\_\_\_
- ☐ Alimony/Spousal Support \$ \_\_\_\_\_
- ☐ Other Income \$ \_\_\_\_\_

Non Cash Benefits: \* ☐ Yes ☐ No

- ☐ Supplemental Nutrition Assistance Program (SNAP) \$ \_\_\_\_\_
- ☐ Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)
- ☐ TANF Child Care Services
- ☐ TANF Transportation Services
- ☐ Other TANF-Funded Services
- ☐ Other Source

*Self-Sufficiency Matrix and AMI Assessments also available.*  
*Other helpful resources at [www.IndianaBOS.org](http://www.IndianaBOS.org).*